# Commentary

## Learning from patients’ experiences: The case of Travellers’ and their experiences of using health services for skin complaints

This issue of BJD includes an important paper by Gilhooley et al1 who have looked at Irish Traveller women’s experiences of skin disease and their relationships with healthcare providers. The authors – in seeking to understand why travellers do not access healthcare professionals for dermatological health issues - used focus groups with women in the Irish Traveller community. The findings suggest that these women prefer the accessibility of pharmacy provision, and that they also value access to specialist services such as dermatology. In contrast, the authors also found that these women felt they were discriminated against in securing referrals to dermatology services from primary care. However, the authors also found that women’s accounts contained pointers to strategies that can ameliorate many of the problematic issues identified in the research. Gilhooley et al1 recommend tailoring health information for Irish Travellers according to health literacy levels, and that healthcare professionals should demonstrate cultural competence with this group – by customising best evidence to suit the needs of this community.

Gilhooley et al’s1 paper further captures a theme permeating the realm of health studies where there is a growing realisation that sometimes the circumstances of people’s day-to-day lives pose immense challenges to implementing the treatments recommend by well-meaning clinicians2. As treatment and care moves away from clinical settings, the apparent certainty of a clinical recommendation is not only constrained and enabled by people’s everyday life, but also by the resources available to people within their socio-contextual realm3. This trend is explored by a body of research looking into individual and collective *experiences* of health and illness (such as Gilhooley et al’s1 research). Often adopting a qualitative approach, these studies explore the day-to-day barriers and enablers that people experience in self-managing conditions, using health services and/or pursuing healthy behaviours3,4 as well as how the array of options available in a person’s social context shapes their health decision-making and outcomes4,5. Aligned with this, Gilhooley et al’s1 emphasis on improving the health literacy of patients and cultural competence of practitioners shows how it is possible to address both the longstanding effects of barriers to health whilst enhancing people’s skills and ability to pursue healthy lifestyles.

Equally, evidence for the maldistribution of social determinants of health, as well as for patterning of health inequalities, is now well established6. Previous research has consistently shown that Gypsy Roma and Traveller (GRT) communities experience a disproportionately high level of morbidity and mortality7.Parry et al8 conducted the largest study to date on the health of GRT communities and found they have the worst health status of any minority ethnic group in England. Studies of the health and illness experiences of GRT communities have highlighted how discrimination, coupled with a lack of provision for traveller lifestyles within health services, has contributed to this situation9. Our own work4 has shown that the effects of longstanding health inequalities experienced by GRT communities, shapes their decision making around health. For example, as GRT children are frequently ill (relative to the wider population) and their mothers often find it difficult to access services, this means there are very few windows of opportunity where children can receive vaccinations10. This contributes to low levels of childhood immunisation in GRT communities - which further perpetuates the health inequalities they experience4,10. Gilhooley et al’s1 research is an exemplar of how, by listening to service users’ experiences of accessing treatment and considering clinical recommendations in light of this, practitioners can improve the likelihood of an intervention being taken up, adopted and successful – and thus makes steps towards reducing the factors that perpetuate the health inequalities GRT communities experience.

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**Conflicts of Interest**

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